sible for any diminished intelligence among toddlers with lead problems.

Second, the addition of iron to prepared infant formulas and to children's chewable vitamins has drastically curtailed clinical (and chemical) iron deficiency among both bottle-fed and breast-fed toddlers. This reduction in iron deficiency significantly predates the recent drastic reduction in lead contamination in our environment. Thus, we have seen the prevalence of high blood lead levels plummet among children less than 6 years of age, from more than 88% of those sampled two decades ago to less than 9% of those sampled in the early 1990s. A recent survey of children receiving Medicaid in California found that the lead levels in the blood of these children had plummeted even further so that less than 2% had blood lead levels higher than 0.1 μg/mL.[1] At almost the same time Kaiser Permanente in California confirmed that only 4% of 636 children tested at four different sites had lead levels in excess of 0.1 μg/mL.[2] In Idaho, not even one of 1500 children tested had an elevated blood lead level.

As the lead problem approaches extinction, scientists would still do well to seek further understanding of the apparent interrelations among lead, zinc and iron — and possibly other metals — and the individual and combined effect of these metals — if any — on intelligence. If we add 5 or 10 points to our collective intelligence quotient, addiction to television soap operas may follow lead poisoning to extinction.

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NEED FOR UNIVERSITY STUDENT HEALTH SERVICES GROWING

The article "On-campus physicians witnessing changes in medical problems faced by university students" (*Can Med Assoc J* 1995; 154: 77–79), by Susan Thorne, was welcome and timely. University health services, and psychiatric services in particular, have been under siege for the past few years. As an area of medicine we suffer under the double burden of university administrations, which view us as necessary but expensive evils, and our medical colleagues, who see us as practising country-club medicine, unworthy of respect or support. Our patients suffer because of these attitudes.

From a survey we conducted at Queen's University, Kingston, Ont., we know that health plays a central role in students' decisions not to return to university. A review of first-year students who did not return after the 1988 academic year revealed that 7.6% definitely did not return because of health problems and another 20% probably or possibly did not return because of health problems. We suspect that a large number were able to stay in university because their health problems were adequately addressed at school.

As our society changes, so do universities. These changes highlight the increasing importance of our service. There were 853 visits to our psychiatric service in the 1980–81 school year. In 1990–91 there were 3279 visits, and in 1994–95 there were 5907 visits. Although we continue to serve the "classic" psychiatric needs of a student population (i.e., students who are in a crisis or having an adjustment reaction and need help for only a few sessions), there is a second population that has formed a large portion of our practice in the 1990s. These students often require regular psychiatric care throughout their university years. The growth of this population is reflected in the growth in the proportion of patients seen by the psychiatric service who are taking medication, from 27% in 1981 to 52% in 1991. The mean number of sessions per patient doubled during the same period. This new population consists mainly of older students, who are often returning to school part-time and trying to reconstruct their lives. One particular telling statistic is that 26% of students who sought psychiatric care at the clinic in 1991 reported a history of childhood sexual abuse, whereas no students reported such a history in 1981.[1]

In a small community like Kingston, can you imagine how local physicians could accommodate an additional 600 psychiatric patients and another 8000 patients seeking family medical care, for a total of 25 000 to 30 000 visits during the year, especially since most family practices are closed to new patients and the wait to see a psychiatrist is 3 to 6 months?

Can you imagine the cost in time, money and human suffering if students did not have access to timely, sensitive care? Sadly, if university health services are cut back or eliminated in the name of cost constraint, we may find out.

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